910 QUALITY MANAGEMENT/PERFORMANCE IMPROVEMENT (QM/PI) PROGRAM SCOPE

EFFECTIVE DATES: 10/01/94, 10/01/17

REVISION DATES: 10/01/97, 10/01/01, 08/13/03, 04/01/05, 02/01/07, 06/01/07, 10/01/08, 10/01/09, 02/01/11, 04/01/12, 10/01/13, 03/01/14, 10/01/15, 10/01/16, 03/01/18

I. PURPOSE

This Policy applies to Acute Care, ALTCS/EPD, CRS, DCS/CMDP, DES DDD (DDD), and RBHA Contractors. For Fee-For-Services (FFS) Programs and all FFS populations, excluding Federal Emergency Services (FES) unless otherwise delineated within this policy. (For FES, see AMPM Chapter 1100), this policy is only applicable to the Quality of Care concern components, which are further outlined in AMPM Policy 960. This Policy establishes requirements regarding the scope and requirements of the Quality Management/Quality Improvement Program.

II. DEFINITIONS

ACCESS	The timely use of services to achieve optimal outcomes, as evidenced by managed care plans successfully demonstrating and reporting on outcome information for the availability and timeliness elements defined under 42 CFR 438.68 (Network adequacy standards) and 42 CFR 438.206 (Availability of services) (42 CFR 438.320).
AHCCCS QUALITY IMPROVEMENT (QI) TEAM	Team of AHCCCS staff that evaluates Contractor Quality Management/Performance Improvement (QM/PI) Programs; monitors compliance with required Quality/Performance Improvement Standards, Contractor Corrective Action Plans (CAPs) and Performance Improvement Projects (PIPs); and provides technical assistance for QM/PI related matters.
AHCCCS QUALITY MANAGEMENT (QM) TEAM	Team of AHCCCS staff that researches and evaluates Quality of Care (QOC) concerns; provides oversight of contractor credentialing and delegation processes; monitors compliance with required quality standards and Contractor Corrective Action Plans (CAPs); and provides technical assistance for Quality Management (QM) related matters.
ASSESS OR EVALUATE	The process used to examine and determine the level of quality or the progress toward improvement of quality and/or performance related to Contractor service delivery systems.

HEALTH CARE SERVICES	All Medicaid services provided by an MCO under contract with the State Medicaid agency in any setting, including but not limited to medical care, behavioral health care, and long-term services and supports (42 CFR 438.320).
HEALTH INFORMATION SYSTEM	Data system composed of the resources, technology, and methods required to optimize the acquisition, storage, retrieval, analysis, and use of data. Health informatics tools include not only computers but also clinical guidelines, formal medical terminologies, and information and communication systems.
MONITORING	The process of auditing, observing, evaluating, analyzing and conducting follow-up activities, and documenting results via desktop or on-site review.
PERFORMANCE IMPROVEMENT/QUALITY IMPROVEMENT	The continuous study and improvement of processes with the intent to better services or outcomes, and prevent or decrease the likelihood of problems, by identifying areas of opportunity and testing new approaches to fix underlying causes of persistent/systemic problems or barriers to improvement.
PERFORMANCE IMPROVEMENT PROJECT (PIP)	A planned process of data gathering, evaluation, and analysis to determine interventions or activities that are projected to have a positive outcome. A PIP includes measuring the impact of the interventions or activities toward improving the Quality of care and service delivery.
OUTCOMES	Changes in patient health, functional status, satisfaction, or goal achievement that result from health care or supportive services (42 CFR 438.320).
QUALITY	As it pertains to external Quality review, means the degree to which an MCO increases the likelihood of desired Outcomes of its enrollees through: 1. Its structural and operational characteristics, 2. The provision of services that are consistent with current professional, evidenced-based-knowledge, and 3. Interventions for performance improvement (42 CFR 438.320).

III. POLICY

A. QUALITY MANAGEMENT/PERFORMANCE IMPROVEMENT (QM/PI) PROGRAM

1. Contractors shall establish and implement a Quality Management/Performance Improvement (QM/PI) Program that shall include at least the following elements [42 CFR 438.330(b)]:
   a. Performance Improvement Projects (PIPs),
   b. Collection and submission of performance measurement data,
   c. Mechanisms to detect both under and overutilization of services, and
   d. Mechanisms to Assess the Quality and appropriateness of care furnished to enrollees with special health care needs.

2. For Contractors providing long-term services and supports, the Contractors QM/PI Program shall also include [42 CFR 438.330(b)(5)]:
   a. Mechanisms to Assess the Quality and appropriateness of care furnished to enrollees using long-term services and supports, including Assessment of care between care settings and a comparison of services and supports received with those set forth in the enrollee's treatment/service plan, if applicable, and
   b. Participation in efforts by the State to prevent, detect, and remediate critical incidents that are based, at a minimum, on the requirements on the State for home and community-based waiver programs.

B. QUALITY MANAGEMENT/PERFORMANCE IMPROVEMENT (QM/PI) PROGRAM COMPONENTS

1. As part of the Quality Management/ Performance Improvement (QM/PI) Program, Contractors shall:
   a. Demonstrate that Members' rights and responsibilities are defined, implemented and monitored,
   b. Ensure that medical records and communication of clinical information for each member reflects all aspects of member care, including ancillary and behavioral health services, in compliance with AMPM Policy 940. Supporting policies shall include processes for digital (electronic) signatures when electronic documents are utilized,
   c. Conduct the temporary/provisional, initial and credentialing processes for individual and organizational providers in accordance with the requirements of AMPM Policy 950,
   d. Implement a process for grievance resolution, tracking and trending that meets the standards set in AMPM Policy 960, 42 CFR 438.400, and 42 CFR 438.242 *et seq*,
   e. Develop and implement planned activities to meet or exceed AHCCCS-mandated performance measures Minimum Performance Standards (MPS), as specified in AHCCCS Contract and required by AMPM Policy 970, and PIP goals, as required by AMPM Policy 980,
   f. Ensure and demonstrate ongoing communication and collaboration between the QM/PI Program and other functional areas of the organization such as, but not limited

to: Medical Management, Member Services, Behavioral Health, Provider Relations, Grievance and Appeals, Fraud, Waste and Abuse, and Case Management,

g. Demonstrate the incorporation of input from AHCCCS members, stakeholders, advocates, and contracted providers in matters related to the QM/QI Program activities,
h. Develop and implement a process for Monitoring the Quality and coordination between behavioral and physical health services. The process shall include procedures utilized to:
    i. Ensure timely updates occur between Primary Care Physicians (PCPs) and behavioral health providers regarding a member's change in health status. The updates shall include, but are not limited to:
        1) Diagnosis of chronic conditions,
        2) Changes in physical and/or behavioral health condition or diagnosis,
        3) Support for the petitioning process, if applicable,
        4) Transition to or from an integrated RBHA program (based on SMI status), when appropriate. This could include transitions for:
            a) Qualifying opt-out conditions,
            b) Inter-RBHA transfers (across GSA),
            c) Intra-RBHA transfer (provider to provider but across county, within same GSA, and
        5) All medication prescribed, and/or changes made in medication or dosage.
i. Promote timely engagement and appropriate service levels for adult members, as well as enrolled youth and caregivers,
j. Identify methodology for High Needs Case Management (HNCM) service provision to adult members,
k. For Members that meet criteria for High Needs Case Management (either SMI or GMHSA), there shall be coordination between Care Management at the MCO/RBHA level and Case Management at the Behavioral Health Provider level,
l. Identify protocol/practices to monitor appropriate use of methodologies for screening/ identification of high needs adult members,
m. Identify standards for adults with an SMI diagnosis for all levels of service intensity (e.g. levels of care/case management),
n. Establish mechanisms to connect members and families to family run organizations,
o. Provide training and Monitoring for provider use of Substance Abuse Mental Health Services Administration (SAMHSA) Fidelity Tools including Assertive Community Treatment, Supported Employment, Supportive Housing, and Consumer Operated Services,
p. Provide training of clinical and general staff (including front office staff) on eligibility and use of services available for substance use prevention and/or treatment through funds available for individuals that are Non-Title XIX eligible including but not limited to Substance Abuse Block Grant (SABG) and Mental Health Block Grant (MHBG) funding. Promote Evidence Based Practices in Substance Use Disorder Treatment Services,
q. Identify and refer youth and young adults to the behavioral health system when identified as having a diagnosed substance use disorder,

r. Ensure the completion of American Society of Addiction Medicine (ASAM) Criteria Assessment for individuals in need of Substance Use Disorder Treatment Services,
s. Increase physical health care providers' knowledge of health related topics including brief substance use screening, overdose reversal medications, and Medication Assisted Treatment (MAT) options available to members,
t. Promote suicide prevention (following Zero Suicide Model) to support the identification and referral of members in need of behavioral health/crisis. Promotion and referral should include, but not be limited to:
    i. Community members,
    ii. Physical health providers,
    iii. Behavioral health providers,
    iv. Interested stakeholders,
    v. Agencies that serve individuals at increased risk for suicide (Veterans, individuals with PTSD, Native Americans, middle aged white males, members of the Lesbian, Gay, Bisexual and/or Transgender (LGBTQ) community, foster care, those age 65 and older, juvenile justice).
u. Identify veteran and service member enrollment within the behavioral health system and initiate referrals when behavioral health needs are identified,
w. Implement policies and procedures that require the individual and organizational providers to report to the proper authorities, as well as the Contractor, incidents of abuse, neglect, injuries (e.g. falls and fractures), exploitation, healthcare acquired conditions, and or unexpected death as soon as the providers are aware of the incident. Behavioral health providers shall submit Incident, Accident, and Death reports to the Contractor in accordance with Arizona Administrative Code Title 9, Chapter 10 [9 A.A.C. 10] and AMPM Policy 960,
x. Implement policies and procedures that require individual and organizational providers to monitor and trend all suicides or attempted suicides,
y. Implement policies and procedures to ensure that all providers recognize signs and symptoms of suicidal ideation and at-risk behaviors for children and adults regardless of mental health status,
    i. Policies and procedures shall identify requirements for care coordination between behavioral health providers and PCPs or other medical practitioners involved in member's care in the event that a behavioral or physical health practitioner witness a patient with suicidal ideation or at-risk behaviors.
z. Conduct new member Health Risk Assessments (HRA) within 90 days of the member's effective enrollment date. Contractors shall develop and implement a process to ensure that a "best effort" attempt has been made to conduct an initial HRA of each member's health care needs. The process shall also address activities to follow up on unsuccessful attempts to contact a member within 90 days of the effective date of enrollment. Each attempt shall be documented. Contractors shall develop processes to utilize the results of HRAs to identify individuals at risk for and/or with special health care needs, and coordinate care (42 CFR 438.208),
    i. Refer to AMPM Policy 1620 and Exhibit 1620-1 to obtain time frames for which case managers/support coordinators shall have an initial contact with newly enrolled Arizona Long Term Care System (ALTCS) members, and

ii. Refer to AMPM Policy 580 and ACOM Policy 417 to obtain time frames for which Contractors shall have initial contact with referred members for behavioral health services.

aa. Ensure continuity of care and integration of services utilizing:

i. Programs for care coordination that include coordination of covered services with community and social services, generally available through contracted or non-contracted providers within the Contractor's service area,

ii. Monitoring of referral activities for both the PCP and the behavioral health provider during referral to, coordination of care with, and transfer of care between the PCP and the behavioral health provider,

iii. Monitoring to ensure that when a member is transitioning from the physical health provider to the behavioral health provider (or vice-versa) that bridge medications are provided according to AMPM Policy 310-V,

iv. Monitoring of PCP's coordination of care with the Behavioral Health Medical Professional (BHMP), when PCPs are providing medical management services for the treatment of mild depression, anxiety, Attention Deficit Hyperactivity Disorder (ADHD), or Opioid Use Disorder (OUD) for members with Serious Mental Illness (SMI). Monitoring shall ensure that medication management by the PCPs is given within the PCP's scope of practice,

v. Monitoring when PCP is providing treatment of mild depression, anxiety, ADHD, or OUD to ensure that medications are not contraindicated, based on member's serious mental illness designation or other behavioral health condition and/or functional status,

vi. Monitoring when a PCP is providing medical management services for a member to treat a behavioral health disorder, and it is subsequently determined by the PCP and RBHA that the recipient should receive care through the behavioral health system, for evaluation and/or continued medication management services, the RBHA subcontracted providers will assist the PCP with the coordination of the referral and transfer of care. The PCP and the involved behavioral health provider will document the care coordination activities and transition of care in the medical record,

vii. Utilizing Arizona's Controlled Substances Prescription Monitoring Program (CSPMP), as required under Contract,

viii. Monitoring of the behavioral health provider's referral to, coordination of care with, and transfer of care to PCP, as well as usage of Arizona's Controlled Substances Prescription Monitoring Program (CSPMP), as required under Contract,

ix. Monitoring of coordination between behavioral health providers and PCPs or other medical practitioners involved in member's care in the event that a behavioral or physical health practitioner witness a patient with suicidal ideation or at-risk behaviors.

bb. Implement policies and procedures that outline:

i. The process for members selecting, or the Contractor assigning, a PCP who is formally designated as having primary responsibility for coordinating the members overall health care. The PCP shall coordinate care for the member including coordination with the BHMP and/or BHP,

ii. Processes for provision of appropriate medication Monitoring for members taking antipsychotic medication (per national guidelines):
  a) Monitoring metabolic parameters for lithium, valproic acid, carbamazepine,
  b) Renal function, liver function, thyroid function, glucose metabolism, screening for metabolic syndrome and involuntary movement disorders,
  c) Provision of medication titration according to, drug class requirements and appropriate standards of care:
    i.) The circumstances under which services are coordinated by the Contractor, the methods for coordination, and specific documentation of these processes,
    ii.) Specify services coordinated by the Contractor's Disease Management Unit, and
    iii.) The requirements for timely and confidential communication of clinical information among providers, as specified in AMPM Policy 940.

cc. Implement measures to ensure that members:
  i. Are informed of specific health care needs that require follow-up,
  ii. Receive, as appropriate, training in self-care and other measures they may take to promote their own health. Available services are listed within the AHCCCS Behavioral Health Services Guide under the section describing various "Rehabilitation Services" (i.e. "Skills Training & Development", Behavioral Health Prevention/Promotion Education and Medication Training and Support Services "),
  iii. Are informed of their rights and responsibilities including, but not limited to the responsibility to adhere to ordered treatments or regimens.

dd. Develop and implement procedures for members with special health care needs, as defined in the AHCCCS Contract, including:
  i. Identifying members with special health care needs, including those who would benefit from disease management,
  ii. Ensuring an Assessment by an appropriate health care professional of ongoing needs of each member identified as having special health care need(s) or condition(s),
  iii. Identifying medical procedures (and/or behavioral health services, as applicable) to address and/or monitor the need(s) or condition(s),
  iv. Ensuring adequate care coordination among providers, including but not limited to, other Contractors/insurers and behavioral health providers, as necessary, and
  v. Ensuring a mechanism to allow direct Access to a specialist as appropriate for the member's condition and identified special health care needs (e.g., a standing referral or an approved number of visits),
  vi. Implement processes and measures to ensure that members receive Special Assistance, based on criteria identified within AMPM Policy 320-R.

ee. Maintain a Health Information System that collects, integrates, analyzes, validates and reports data necessary to implement its QM/PI Program (42 CFR 438.242).
  Data elements shall include:
  i. Member demographics and encounter data,
  ii. Provider characteristics,
  iii. Services provided to members, and

iv. Other information necessary to guide the selection of, and meet the data collection requirements for performance measures, PIPs and QM/PI oversight.

ff. Ensure the following requirements related to data integrity:
   i. Information/data received from providers is accurate, timely, and complete,
   ii. Reported data is reviewed for accuracy, completeness, logic, and consistency, and the review and evaluation processes used are clearly documented. Information that is rejected shall be tracked to ensure errors are corrected and the data is resubmitted and accepted,
   iii. Contractor staff and providers are kept informed of at least the following:
      1) QM/PI requirements, activities, updates or revisions,
      2) Study and PIP results,
      3) Performance measures and results,
      4) Utilization data, and
      5) Profiling results.
   iv. All member and provider information is protected by Federal and State law, regulations, or policies is kept confidential, and
   v. Maintenance of records and documentation as required under State and Federal law.

All QM/PI Program Components shall be supported through the development, implementation, and maintenance of policies and procedures. All policies and procedures shall be specific to each line of business.

C. QM/PI PROGRAM ADMINISTRATIVE STRUCTURE/OVERSIGHT

The Contractor's QM/PI Program shall be administered through a clear and appropriate administrative structure that maintains the ultimate responsibility for the QM/PI Program. The QM/PI work shall reside within the Quality Management Unit.

1. The Contractor's Administrative Structure for oversight of its QM/PI Program shall adhere to requirements of this section, as well as AMPM Policies 910-980, which outline the roles and responsibilities of the following:
   a. The governing or policy-making body,
   b. The Medical Director,
   c. The QM/PI Committee,
   d. The Peer Review Committee,
   e. QM/PI Staff, and
   f. The Contractor's executive management.

2. Governing or Policy Making Body

   The governing or policy making body shall oversee and be accountable for the QM/PI Program.
   a. The Board of Directors, and in the absence of a Board, the executive body, shall review and approve the QM/QI Program Annual Plan, as demonstrated via an attestation of approval by the Board of Directors or executive body.

b. The Board of Directors, and in the absence of a Board, the executive body formally Evaluates and documents the effectiveness of its QM/PI Program strategy and activities, at least annually, as demonstrated via an attestation of approval by the Board of Directors or executive body.

3. Medical Director
The local Medical Director is responsible for implementation of the QM/PI Program Annual Plan and shall have substantial involvement in the implementation, Assessment, and resulting improvement of QM/PI Program activities. All Quality management/ Performance Improvement policies shall be approved and signed by the Contractor's Medical Director.

4. QM/PI Committee
The Contractor shall have an identifiable and structured local (Arizona) QM/PI Committee that is responsible for QM/PI functions and responsibilities.
   a. At a minimum, the membership shall include:
      i. The local Medical Director as the chairperson of the Committee. The local Medical Director may designate the local Associate Medical Director as his/her designee only when the Medical Director is unable to attend the meeting. The local Chief Executive Officer may be identified as the co-Chair of the QM/PI Committee,
      ii. The QM/PI Manager(s),
      iii. Representation from the functional areas within the organization,
      iv. Representation of contracted or affiliated providers serving AHCCCS members, and
      v. Clinical representatives of both the Contractor and the provider network.
   b. The QM/PI Committee shall ensure that each of its members is aware of the requirements related to confidentiality and conflicts of interest by having signed statements on file and/or QM/PI Committee sign-in sheets with requirements noted,
   c. The QM/PI Committee shall meet, at a minimum, quarterly or more frequently as needed. The frequency of committee meetings shall be sufficient to monitor all program requirements and to monitor any required actions. Contractor shall provide evidence of actual occurrence of these meetings through minutes and other supporting documentation,
   d. The QM/PI Committee shall review the QM/PI Program objectives, policies and procedures as specified in Contract and shall modify (or update) the policies when processes/activities are changed substantially. The QM/PI policies and procedures, and any subsequent modification to them, shall be available upon request for review by AHCCCS, Division of Health Care Management, Quality Management or Quality Improvement Teams,
   e. The QM/PI Committee shall also:
      i. Review, Evaluate, and approve any changes to the QM/PI Program Plan,
      ii. Develop procedures for QM/PI responsibilities and clearly document the processes for each QM/PI Program function and activity,

iii. Develop and implement procedures to ensure that Contractor staff and providers are informed of the most current QM/PI Program requirements, policies and procedures, and
iv. Develop and implement procedures to ensure that providers are informed of information related to their performance [such as results of studies, AHCCCS Performance Measures, profiling data, medical record review results, utilization data such as Performance Improvement, prescribing practices, Emergency Room (ER) utilization, etc.].

f. When deficiencies are noted, the QM/PI Committee meeting minutes shall clearly document discussions of the following:
   i. Identified issues,
   ii. Responsible party for interventions or activities,
   iii. Proposed actions,
   iv. Evaluation of the actions taken,
   v. Timelines including start and end dates, and
   vi. Additional recommendations or acceptance of the results as applicable.

5. Peer Review

The Contractor shall have a peer review process with the purpose of improving the Quality of care provided to members by providers, both individual and organizational providers. The peer review scope includes cases where there is evidence of deficient Quality, or the omission of the care or service provided by a participating, or non-participating, physical or behavioral health care professional or provider whether delivered in or out of state. Peer review shall be defined by specific policies and procedures which shall address the following requirements:

a. Contractors shall not delegate functions of peer review to other entities,
b. The Peer Review Committee shall be scheduled to meet at least quarterly,
c. Peer review activities may be carried out as a stand-alone committee or in an executive session of the Contractor's Quality Management Committee,
d. At a minimum, the Peer Review Committee shall consist of:
   i. Contractor's local Chief Medical Officer as Chair,
   ii. Contracted medical providers from the community that serve AHCCCS members,
   iii. A Contracted behavioral health provider from the community that serves AHCCCS members.

   The peer review process shall ensure that providers of the same or similar specialty participate in review and recommendation of individual peer review cases. If the specialty being reviewed is not represented on the contractor's Peer Review Committee, the Contractor may utilize peers of the same or similar specialty through external consultation.
e. Peer Review Committee members shall sign (may be an electronic signature) a confidentiality and conflict of interest statement at each Peer Review Committee meeting. Committee members shall not participate in peer review activities if they have a direct or indirect interest in the peer review outcome,
f. The Peer Review Committee shall Evaluate referred cases based on all information made available through the Quality management process,

g. The Peer Review Committee is responsible for making recommendations to the Contractor's Medical Director. The Peer Review Committee shall determine appropriate action which may include, but is not limited to: peer contact, education, reduced or revoked credentials, and limit on new member enrollment, sanctions, or other corrective actions. The Medical Director is responsible for implementing the actions. Adverse actions taken as a result of the Peer Review Committee shall be reported to AHCCCS within 24 hours of an adverse decision being made,
h. The Peer Review Committee is responsible for making appropriate recommendations to the Contractor's Medical Director regarding initiation of referrals for further investigation or action to: the Department of Child Safety (DCS), Adult Protective Services (APS), the Department of Health Services Licensure Unit, the appropriate regulatory agency or board, and AHCCCS. Notification shall occur when the Peer Review Committee determines care was not provided according to the medical community standards. Initial notification may be verbal but shall be followed by a written report to AHCCCS within 24 hours,

   Contractors shall develop a process to timely refer/report the issue to the appropriate regulatory agency [including the Department of Child Safety or Adult Protective Services, Arizona Department of Health Services (ADHS), the Attorney General's Office, law enforcement and AHCCCS Clinical Quality Management] for further research, review or action. Initial reporting may be made verbally, but shall be followed by a written report within one business day.

i. Peer Review Committee policies and procedures shall assure that all information used in the peer review process is kept confidential and is not discussed outside of the peer review process. The Contractor's Peer Review Committee reports, meetings, minutes, documents, recommendations, and participants shall be kept confidential except for implementing recommendations made by the Peer Review Committee,
j. Peer review documentation shall be made available to AHCCCS for purposes of Quality management, Monitoring and oversight,
k. High-level peer review summaries shall be maintained as part of the original QOC file,
l. Contractors shall demonstrate:
   i. How the peer review process is used to analyze and address clinical issues.
   ii. How providers are made aware of the peer review process, and
   iii. How providers are made aware of the procedure for grieving peer review findings.
m. Matters appropriate for peer review shall include, but are not limited to:
   i. Cases where there is evidence of deficient Quality,
   ii. An omission of the care or service provided by a participating or non-participating physical health care or behavioral health care provider,
   iii. Questionable clinical decisions, lack of care and/or substandard care,
   iv. Inappropriate interpersonal interactions or unethical behavior, physical, psychological, or verbal abuse of a member, family, staff, or other disruptive behavior,
   v. Allegations of criminal or felonious actions related to practice,

vi. Issues that immediately impact the member and that are life threatening or dangerous,
vii. Attempted suicide,
viii. Opioid-involved/related cases,
ix. Unanticipated death of a member,
x. Issues that have the potential for adverse outcome, or
xi. Allegations from any source that bring into question the standard of practice.

6. QM/PI Staffing

The QM/PI Program shall have qualified local personnel to carry out the functions and responsibilities specified in this Chapter in a timely and competent manner. QM/PI positions performing work functions related to the Contract shall have a direct reporting relationship to the local Chief Medical Officer (CMO) and the Chief Executive Officer (CEO). Contractors are responsible for Contract performance, whether or not subcontractors or delegated entities are used.
As part of the QM/PI Program Staffing requirements, the Contractor shall:

a. Maintain an organizational chart that shows the reporting relationships for QM/PI activities and the percent of time dedicated to the position for each specific line of business:
   i. The QM/PI Program organizational chart shall be maintained and demonstrate the current reporting structures, including the number of full time and part time positions, staff names and responsibilities, and
   ii. This chart shall also show direct oversight of QM/PI activities by the local Medical Director and the implemented process for reporting to Executive Management.
b. Develop a process to ensure that all staff is trained on the process for referring suspected Quality of Care (QOC) concerns to the Quality Management Team. This training shall be provided during new employee orientation and, at a minimum, annually thereafter,
c. Develop and implement policies and procedures outlining:
   i. QM/PI staff qualifications including education, certifications, experience and training for each QM/PI position, and
   ii. Mandatory QM/PI Staff/Management attendance at AHCCCS Contractor meetings, unless attendance is specified as optional by AHCCCS.
d. Participate in (and maintain associated documentation for) applicable community initiatives, such as, but not limited to:
   i. Quality management and Quality improvement,
   ii. Maternal child health,
   iii. Early and Periodic Screening, Diagnosis and Treatment (EPSDT),
   iv. Disease management,
   v. Behavioral health,
   vi. Contractor participation in specific community initiatives and collaborations, if required by AHCCCS, and
   vii. Long-term care

AHCCCS sponsored activities are not considered community initiatives or collaborations.

7. Delegated Entities

The Contractor shall oversee and maintain accountability for all functions and responsibilities described in this Chapter, which are delegated to other entities. The methodologies for oversight and accountability for all delegated functions shall be integrated into the overall QM/PI Program, with the requirements of this Policy and AMPM Policies 920-980 being met for all delegated functions. Accredited agencies shall be included in the Contractor's oversight process.

a. As a prerequisite to delegation, the Contractor shall provide a written analysis of its historical provision of QM/PI Program oversight function, which includes past goals and objectives. The level of effectiveness of the prior QM/PI Program oversight functions shall be documented. Examples may include the number of claims, concerns, grievances or network gaps,
b. The Contractor shall have policies and procedures requiring that the delegated entity report all allegations of Quality of care and Quality of service issues to the Contractor. QOC or service investigation and resolution processes shall not be delegated,
c. The Contractor shall Evaluate the entity's ability to perform the delegated activities prior to delegation. Evidence of such evaluation includes the following:
    i. Review of appropriate internal areas, such as Quality management,
    ii. Review of policies and procedures and the implementation of them, and
    iii. Documented evaluation and determination that the entity is able to effectively perform the delegated activities.
d. Prior to delegation, a written contract shall be established that specifies the delegated activities and reporting responsibilities of the entity to the Contractor. The agreement shall include the Contractor's right to terminate the contract or perform other remedies for inadequate performance.
e. The performance of the entity and the Quality of services provided are monitored on an ongoing basis and are annually reviewed by the Contractor. Annually, the Contractor shall review a minimum of 30 randomly selected files per line of business for each function that is delegated. Documentation shall be kept on file for AHCCCS review. Monitoring should include, but is not limited to:
    i. Utilization,
    ii. Member and provider satisfaction,
    iii. QOC concerns, and
    iv. Complaints.
f. The following documentation shall be kept on file and available for AHCCCS review:
    i. Evaluation reports,
    ii. Results of the Contractor's annual Monitoring review of the delegated entity utilizing AHCCCS required standards for the contracted functions,
    iii. Corrective Action Plans (CAPs), and

iv. Appropriate follow up of the implementation of corrective action plans to ensure that Quality and compliance with AHCCCS requirements for all delegated activities or functions are met.

D. QM/PI PROGRAM MONITORING AND EVALUATION ACTIVITIES

The Contractor shall develop and implement mechanisms to monitor and Evaluate its service delivery system and provider network that demonstrates compliance with all the requirements included within this Policy, as well as those requirements listed within this section.

QM/PI Program Monitoring and evaluation activities shall include, but are not limited to, the following:

1. QM/PI Program scope of Monitoring and evaluation shall be comprehensive. It shall incorporate the activities used by the Contractor and demonstrate how these activities will improve the Quality of services and the continuum of care in all services sites. These activities shall be clearly documented in policies and procedures.

2. If collaborative opportunities exist to coordinate organizational Monitoring, the lead Contractor shall coordinate and ensure that all requirements in the collaborative arrangement are met.

3. Information and data gleaned from QM Monitoring and evaluation that shows trends in QOC concerns shall be used in developing PI projects. Selection of specific Monitoring and evaluation activities shall be appropriate to each specific service or site.

3. Development and implementation of methods for Monitoring PCP activities related to:
   a. Referrals for behavioral health care,
   b. Coordination with the behavioral health system (e.g. RBHAs and Behavioral Health Providers),
   c. Transfer of care, when clinically indicated, based on severity of behavioral health need, and
   d. Use of the CSPMP. Monitoring procedures for the CSPMP process shall include:
      i. Assurance of communication between prescribers, when controlled substances are used,
      ii. Provider-mandated usage of the CSPMP, and
      iii. Integration strategies and activities focused on improving individual health Outcomes, enhancing care coordination, and increasing member satisfaction.

4. Development and implementation of methods for Monitoring behavioral health provider activities related to:
   a. Referrals for medical/physical health care,
   b. Coordination with the medical/physical health system,
   c. Use of the CSPMP. Monitoring procedures for the CSPMP process shall include:

i. Assurance of communication between prescribers, when controlled substances are used,
ii. Include provider-mandated usage of the CSPMP, and
iii. Integration strategies and activities focused on improving individual health Outcomes, enhancing care coordination, and increasing member satisfaction.

5. Reporting of all Quality of Care concerns including, but not limited to:
   a. Incidents of abuse, neglect, exploitation, attempted suicide, and unexpected deaths to the AHCCCS Quality Management Team as soon as the Contractor is aware of the incident, as specified in Contract. Contractors are expected to investigate and report case findings, including identification of organizational providers, individual providers, paid caregivers, or the specific individual rendering the service,
   b. Identified QOC concerns, reportable incidents and/or service trends to the AHCCCS Quality Management Team immediately upon identification. Reporting shall include trend specifications such as providers, facilities, services, and allegation types,
      i. Contractor QOC trend reports shall be incorporated into Monitoring and evaluation activities, and presented to the QM/PI Committee. Policies and procedures shall be adopted to explain how the process is routinely completed.
   c. Reporting of Health Care Acquired Conditions (HCAC) and Other Provider Preventable Conditions (OPPC) to the AHCCCS Quality Management Team on a quarterly basis utilizing AMPM Policy 960, Attachment B as specified in Contract. Contractors are expected to investigate all potential HCACs and OPPCs as QOCs and maintain case files that contain findings. (For more information, refer to AMPM Policy 960).

6. Incorporation of the ADHS licensure and certification reports and other publicly reported data in their Monitoring process, as applicable.

7. Conducting on-site reviews by the Contract's Quality Management clinical staff when concerns have been identified as a Health and Safety Concern, Immediate Jeopardy situation or other serious incidents, which impact the health and safety of the member. On-site reviews are to be conducted in accordance with the requirements found in AMPM Policy 960.

   Contractors are responsible for ensuring health and safety of members in placement settings or service sites that are found to have survey deficiencies or suspected issues that may impact the health and safety of AHCCCS members. Contractors shall be active participants in both individual and coordinated efforts to improve the Quality of care in placement settings or service sites. In addition, Contractors shall utilize clinical Quality staff to conduct on-site reviews if there is a health and/or safety concern identified either by the Contractor, AHCCCS, or other party.

8. Monitoring of services and service sites by Contractor Quality Management staff in accordance to Attachment A of this Policy.

9. Implementation of policies and procedures for ALTCS Contractors specific to the annual Monitoring of attendant care, homemaker services, personal care services, respite services and habilitation services. When deficiencies or potential deficiencies are identified, they shall be addressed from a member and from a system perspective.

10. Coordination of mandatory routine Quality Monitoring and oversight activities for organizational providers, including Home and Community Based Service (HCBS) placement settings, when the provider included is in more than one Contractor network. A collaborative process shall be utilized in Maricopa and Pima counties and in counties when more than one Contractor is contracted with and utilizes the facility.

    Contractors (or the lead Contractor, if Contractor collaborative Monitoring was completed) shall submit the Contractor Monitoring Summary to AHCCCS Quality Management (QM) unit annually by December 15, as specified in Contract. Additionally, a standardized and agreed upon tool shall be used and include at a minimum:

    a. General Quality Monitoring of these services includes, but is not limited to, the review and verification of:
        i. The written documentation of timeliness,
        ii. The implementation of contingency plans,
        iii. Customer satisfaction information,
        iv. The effectiveness of service provisions,
        v. Mandatory documents in the services or service site personnel file including:
            a) Cardiopulmonary resuscitation,
            b) First Aid,
            c) Verification of skills or competencies to provide care, and
            d) Evidence that the agency contacted at least three references, one of which shall be a former employer. Results of the contacts shall be documented in the employee's personnel record.
    b. Specific Quality Monitoring requirements are as follows:
        i. Direct Care Services (Attendant care, Personal Care and Homemaker services) Monitoring as described in Attachment B. Monitoring shall include verification and documentation of all of the following:
            (a) Mandated written agreement between the member/guardian/designated representative and the Direct Care Worker (DCW) which delineates the responsibilities of each,
            (b) Evaluation of the appropriateness of allowing the member's immediate relatives to provide direct care services,
            (c) Compliance with ensuring DCWs meet competencies to provide care including training, testing, verifying/ sharing of DCW test records and continuing education requirements in accordance with Attachment B. (For more general information on the DCW training and testing standards, refer to AMPM Policy 1240-A and ACOM Policy 429) and
            (d) Timeliness and content of supervisory visitations as outlined in AMPM Policy 1240-A.

ii. Sampling methodology for Monitoring of direct care, services shall assure that all provider agencies and all employees have an equal opportunity to be sampled (provider agencies shall be included in the sample frame even if the number of employees does not meet a statistically significant level. All employees shall be included in the sample frame including those who are in the pool of workers but are not currently assigned to a member),
iii. Contractors shall monitor that the Long Term Services and Supports (LTSS) a member receives align with those that were documented in the member's LTSS treatment plan [42 CFR 438.330 (b)(5)(i)],
iv. Contractors shall have mechanisms to Assess the Quality and appropriateness of care provided to members receiving LTSS services including between settings of care and, as compared to the member's service plan [42 CFR 438.330 (b)(5)(i)], and
v. Contractors may also consider incorporating the use of surveys to Assess the experience of members receiving LTSS as a key component of the Contractor's LTSS Assessment process.